R590. Insurance, Administration.

R590-203. Health Grievance Review Process and Disability Claims. ***(Effective 12-28-05)***

R590-203-1. Authority.

This rule is specifically authorized by 31A-22-629(4) and 31A-4-116, which requires the commissioner to establish minimum standards for grievance review procedures. The rule is also promulgated pursuant to Subsections 31A-2-201(1) and 31A-2-201(3)(a) in which the commissioner is empowered to administer and enforce this title and to make rules to implement the provisions of this title. The authority to examine insurer records, files, and documentation is provided by 31A-2-203.

R590-203-2. Purpose.

The purpose of this rule is to ensure that insurer's grievance review procedures for individual and group health insurance and income replacement plans comply with the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for Administration and Enforcement: Claims Procedure, 29 CFR 2560.503-1, Utah Code Sections 31A-4-116 and 31A-22-629.

R590-203-3. Applicability and Scope.

(1) Except as provided in R590-203-3.(3), this rule applies to individual and group:

(a) policies issued or renewed and effective on or after January 1, 2001;

(b) income replacement policies;

(i) including short-term, and

(ii) long-term disability policies;

(c) health insurance; and

(d) health maintenance organization contracts.

(2) Long Term Care and Medicare supplement policies are not considered health insurance for the purpose of this rule.

(3) Income replacement, short-term and long-term disability policies, are exempt from R590-203-6.

R590-203-4. Definitions.

For the purposes of this rule:

(1) “Consumer Representative” may be an employee of the insurer who is a consumer of a health insurance or an income replacement policy, as long as the employee is not[;]:

(a) the individual who made the adverse determination[,]; or

(b) a subordinate to the individual who made the adverse determination.

(2) “Health Insurance” means a contract of:

(a) health care insurance as defined in 31A-1-301; and

(b) health maintenance organization as defined in 31A-8-101.

(3) "Medical Necessity" means:

(a) health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract; and

(b) that when a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For established interventions, the effectiveness shall be based on:

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

(4)(a) "Scientific evidence" means:

(i) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(ii) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

(b) Scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

R590-203-5. Adverse Benefit Determination.

(1) An insurer's adverse benefit determination review procedure shall be compliant with the adverse benefit determination review requirements set forth in the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for Administration and Enforcement: Claims Procedure, 29 CFR 2560.503-1, effective January 20, 2001. This document is incorporated by reference and available for inspection at the Insurance Department and the Department of Administrative Rules.

(2) The provision of this rule and federal regulation applies to claims filed under individual or group plans on or after the first day of the first plan year beginning on or after July 1, 2002, but no later than January 1, 2003.

(3) An insurer's adverse benefit determination appeal board or body shall include at least one consumer representative that shall be present at every meeting.

R590-203-6. Independent and Expedited Adverse Benefit Determination Reviews for Health Insurance.

(1) An insurer shall provide an independent review procedure as a voluntary option for the resolution of adverse benefit determinations of medical necessity.

(2) An independent review procedure shall be conducted by an independent review organization, person, or entity other than the insurer, the plan, the plan's fiduciary, the employer, or any employee or agent of any of the foregoing, that do not have any material professional, familial, or financial conflict of interest with the health plan, any officer, director, or management employee of the health plan, the enrollee, the enrollee's health care provider, the provider's medical group or independent practice association, the health care facility where service would be provided and the developer or manufacturer of the service being provided.

(3) Independent review organizations shall be designated by the insurer, and the

independent review organization chosen shall not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health insurance plan, a national, state, or local trade association of health insurance plans, and a national, state, or local trade association of health care providers.

(4) The submission to an independent review procedure is purely voluntary and left to the discretion of the claimant.

(5) An insurer's voluntary independent review procedure shall:

(a) waive any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a dispute of medical necessity to a voluntary level of appeal provided by the plan;

(b) agree that any statute of limitations or other defense based on timeliness is tolled during the
time a voluntary appeal is pending;

(c) allow a claimant to submit a dispute of medical necessity to a voluntary level of appeal only after exhaustion of the appeals permitted under 29 CFR Subsection 2560.503-1(c)(2), of the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulation for the Administration and Enforcement: Claims Procedure;

(d) upon request from any claimant, provide sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed decision about whether to submit a dispute of medical necessity to the voluntary level of appeal. This information shall contain a statement that the decision to use a voluntary level of appeal will not effect the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimants right to representation, the process for selecting the decision maker.

(e) An independent review conducted in compliance with Section 31A-22-629, and this rule, can be binding on both parties. A claimant’s submission to a binding independent review is purely voluntary and appropriate disclosure and notification must be given as required by the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for Administration and Enforcement: Claims Procedure, 29 CFR 2560.503-1.

(6) Standards for voluntary independent review:

(a) The insurer's internal adverse benefit determination process must be exhausted unless the insurer and insured mutually agree to waive the internal process.

(b) Any adverse benefit determination of medical necessity may be the subject of an independent review.

(c) The claimant has 180 calendar days from the date of the final internal review decision to request an independent review.

(d) An insurer shall use the same minimum standards and times of notification requirement for an independent review that are used for internal levels of review, as set forth in 29 CFR Subsection 2560.503-1(h)(3), (i)(2) and (j).

(7) An insurer shall provide an expedited review process for cases involving urgent care claims.

(8) A request for an expedited review of an adverse benefit determination of medical necessity may be submitted either orally or in writing. If the request is made orally an insurer shall, within 24 hours, send written confirmation to the claimant acknowledging the receipt of the request for an expedited review.

(9) An expedited review requires:

(a) all necessary information, including the plan's original benefit determination, be transmitted between the plan and the claimant by telephone, facsimile, or other

available similarly expeditious method;

(b) an insurer to notify the claimant of the benefit review determination, as soon as possible, taking into account the medical urgency, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination; and

(c) an insurer to use the same minimum standard for timing and notification as set forth in 29 CFR Subsection 2560.503-1(h), 503-1(i)(2)(i), and 503-1(j).

(10) This section, R590-203-6, does not apply to income replacement policies, short term disability policies or long term disability policies.

R590-203-7. Income Replacement, Short-Term and Long-Term Disability, Adverse Benefit Determination Review.

(1) An insurer will notify a claimant of the benefit determination within 45 days of receipt of the claimant's request for review of an adverse benefit determination.

(2) The time period for making a determination on review may be extended for up to 45 days when necessary due to matters beyond the control of the insurer.

(3) If the time period is extended due to the claimant's failure to submit information necessary to decide a claim, the time period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent until the date on which the claimant responds to the request for additional information.

(4) Upon request, relevant information free-of-charge, must be provided to the insured on any adverse benefit determination.

R590-203-8. File and Record Documentation.

An insurer selling health insurance or income replacement insurance, including short-term disability and long-term disability, shall make available upon request by the commissioner, or the commissioner's duly appointed designees, all adverse benefit determination reviews files and related documentation. An insurer shall keep these records for the current calendar year plus five years.

R590-203-9. Compliance.

(1) Insurers are to be compliant with the provisions of this rule and the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for Administration and Enforcement: Claims Procedure, 29 CFR 2560.503-1, by July 1, 2002.

(2) The clarification changes made for income replacement and short-term and long-term disability policies are effective on the date these rule changes take effect.

R590-203-10. Relationship to Federal Rules.

If an insurer complies with the requirements of the Department of Labor, Pension and Welfare Benefits Administration Rules and Regulations for Administration and Enforcement: Claims Procedure, 29 CFR 2560.503-1, then this rule is not applicable to employer plans, except for Sections 4, 5, 6, 7, and 8 of this rule. All individual plans will remain subject to this rule in its entirety.

R590-203-11. Severability.

If a provision or clause of this rule or its application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of these provisions shall not be affected.

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